



**GEORGIA MEDICAID FEE-FOR-SERVICE
BIOLOGIC IMMUNOMODULATORS PA SUMMARY**

Preferred	Non-Preferred
Cosentyx (secukinumab) Enbrel (etanercept) Humira (adalimumab)	Actemra Subcutaneous (tocilizumab) Cimzia (certolizumab) Kineret (anakinra) Orencia Subcutaneous (abatacept) Otezla (apremilast) Simponi (golimumab) Stelara Subcutaneous (ustekinumab) Xeljanz (tofacitinib) Xeljanz XR (tofacitinib extended-release)

LENGTH OF AUTHORIZATION: Varies

NOTES:

- ❖ All preferred and non-preferred products require prior authorization.
- ❖ If medication is being administered in a physician’s office, then it must be billed through the DCH physician’s injectable program and not the outpatient pharmacy program. Information regarding the physician’s injectable program is located at www.mmis.georgia.gov.

PA CRITERIA:

Actemra Subcutaneous

- ❖ Approvable for members 18 years of age or older with moderately to severely active rheumatoid arthritis (RA) when the member has tried methotrexate, alone or in combination with another disease modifying antirheumatic drug (DMARD), Enbrel AND Humira for 3 months each and failed to achieve an adequate response.
- ❖ Member’s absolute neutrophil count (ANC) must be $\geq 2000/\text{mm}^3$, platelet count $\geq 100,000/\text{mm}^3$, and alanine aminotransferase (ALT) and aspartate aminotransferase (AST) within normal limits or less than 1.5 times the upper limit of normal.

Cimzia

- ❖ Approvable for members 18 years of age or older with Crohn’s disease (CD) when the member has tried Humira for 3 months and failed to achieve an adequate response.
- ❖ Approvable for members 18 years of age or older with moderately to severely active rheumatoid arthritis, active psoriatic arthritis, or ankylosing spondylitis when the member has tried Enbrel AND Humira for 3 months each and failed to achieve an adequate response.

Cosentyx

- ❖ Approvable for members 18 years of age or older with moderate to severe plaque psoriasis with $\geq 10\%$ of body surface area involvement when the



member has tried phototherapy AND Humira for 3 months each and failed to achieve an adequate response.

- ❖ Approvable for members 18 years of age or older with active psoriatic arthritis or ankylosing spondylitis when the member has tried Enbrel AND Humira for 3 months each and failed to achieve an adequate response.

Enbrel

- ❖ Approvable for members 18 years of age or older with moderately to severely active rheumatoid arthritis when the member has tried methotrexate alone or in combination with another DMARD for 3 months and failed to achieve an adequate response OR when the member has high disease activity and features of poor prognosis.
- ❖ Approvable for members 18 years of age or older with active psoriatic arthritis when the member has tried a generic DMARD and failed to achieve an adequate response.
- ❖ Approvable for members 18 years of age or older with ankylosing spondylitis when the member has tried two nonsteroidal antiinflammatory drugs (NSAIDs) and failed to achieve an adequate response OR when NSAIDs are contraindicated.
- ❖ Approvable for members 18 years of age or older with moderate to severe plaque psoriasis with $\geq 10\%$ of body surface area involvement when the member has tried phototherapy for 3 months as well as topical AND systemic therapy and failed to achieve an adequate response.
- ❖ Approvable for members 2 years of age or older with juvenile idiopathic arthritis (JIA)/juvenile rheumatoid arthritis (JRA) when the member has tried methotrexate for 3 months and failed to achieve an adequate response OR when methotrexate is contraindicated.

Humira

- ❖ Approvable for members 18 years of age or older with moderately to severely active rheumatoid arthritis when the member has tried methotrexate alone or in combination with another DMARD for 3 months and failed to achieve an adequate response OR when the member has high disease activity and features of poor prognosis.
- ❖ Approvable for members 6 years of age or older with Crohn's disease when the member has tried conventional therapy and failed to achieve an adequate response.
- ❖ Approvable for members 18 years of age or older with active psoriatic arthritis when the member has tried a generic DMARD and failed to achieve an adequate response.
- ❖ Approvable for members 18 years of age or older with ankylosing spondylitis when the member has tried two NSAIDs and failed to achieve an adequate response OR when NSAIDs are contraindicated.
- ❖ Approvable for members 18 years of age or older with moderate to severe plaque psoriasis with $\geq 10\%$ of body surface area involvement when the member has tried phototherapy for 3 months as well as topical AND systemic therapy and failed to achieve an adequate response.



- ❖ Approvable for members 2 years of age or older with juvenile idiopathic arthritis/juvenile rheumatoid arthritis when the member has tried methotrexate for 3 months and failed to achieve an adequate response OR when methotrexate is contraindicated.
- ❖ Approvable for members 18 years of age or older with moderately to severely active ulcerative colitis when the member has tried oral or intravenous corticosteroids AND at least one of the following: 6-mercaptopurine or azathioprine and failed to achieve an adequate response.
- ❖ Approvable for members 18 years of age or older with moderate to severe hidradenitis suppurativa (acne inversa).

Kineret

- ❖ Approvable for members 18 years of age or older with moderately to severely active rheumatoid arthritis when the member has tried Enbrel AND Humira for 3 months each and failed to achieve an adequate response.
- ❖ Approvable for members with neonatal-onset multisystem inflammatory disease (NOMID) associated with cryopyrin-associated periodic syndromes (CAPS).

Orencia Subcutaneous

- ❖ Approvable for members 18 years of age or older with moderately to severely active rheumatoid arthritis (RA) when the member has tried methotrexate, alone or in combination with another disease modifying antirheumatic drug (DMARD), Enbrel AND Humira for 3 months each and failed to achieve an adequate response OR when the member has high disease activity and features of poor prognosis.

Otezla

- ❖ Approvable for members 18 years of age or older with active psoriatic arthritis when the member has tried at least two preferred DMARDs and failed to achieve an adequate response.
- ❖ Approvable for members 18 years of age or older with moderate to severe plaque psoriasis with $\geq 10\%$ of body surface area involvement when the member has tried phototherapy for 3 months AND two preferred systemic therapies and failed to achieve an adequate response.

Simponi

- ❖ Approvable for members 18 years of age or older with moderately to severely active rheumatoid arthritis in combination with methotrexate when the member has tried Enbrel AND Humira for 3 months each and failed to achieve an adequate response.
- ❖ Approvable for members 18 years of age or older with active psoriatic arthritis or ankylosing spondylitis when the member has tried Enbrel AND Humira for 3 months each and failed to achieve an adequate response.
- ❖ Approvable for members 18 years of age or older with moderately to severely active ulcerative colitis when the member has tried Humira for 2 months and failed to achieve an adequate response.

Stelara Subcutaneous

- ❖ Approvable for members 18 years of age or older with moderate to severe plaque psoriasis with $\geq 10\%$ of body surface area involvement when the



member has tried phototherapy, Enbrel AND Humira for 3 months each and failed to achieve an adequate response.

- ❖ Approvable for members 18 years of age or older with active psoriatic arthritis when the member has tried Enbrel AND Humira for 3 months each and failed to achieve an adequate response.

Xeljanz and Xeljanz XR

- ❖ Approvable for members 18 years of age or older with moderately to severely active rheumatoid arthritis when member has tried methotrexate, alone or in combination with another DMARD, Enbrel AND Humira for 3 months each and failed to achieve an adequate response.
- ❖ In addition to meeting the criteria above for Xeljanz XR, prescriber must also submit a written letter of medical necessity stating the reasons Xeljanz (regular-release) is not appropriate for the member.

EXCEPTIONS:

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- ❖ For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

PA and APPEAL PROCESS:

- ❖ For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.